STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HOME	203 FRANCISCAN DRIVE CROWN POINT, IN46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 25, 26, 27, 28, and May 2, 2011 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Survey team: Marcia Mital, RN, TC Sheila Sizemore, RN, Kelly Sizemore, RN (April 25, 26, 27, and 28, 2011) Regina Sanders, RN (April 25 and 26, 2011) Census bed type: SNF: 30 NF: 111 SNF/NF: 30 NCC: 12 Total: 183 Census Payor type: Medicare: 30 Medicaid: 103 Other: 50 Total: 183 Sample: 26	F0000	St. Anthony Home ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Supplemental sample: 6 NCC Sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 5-5-11 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed notify a resident's physician of a resident having	F0157	1.1 Regarding resident #135, Unit Nurse Manager / designee immediately assessed resident on 4/26/11 with no adverse reactions noted. Unit Nurse Manager notified physician and family of the occurrence on 4/26/11. 1.2 Unit Nurse Managers / designees reviewed current 24-hour reports related to	06/01/2011

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	constipation for 1 of 26 residents reviewed for physician notification in a total sample of 26. (Resident #135) Findings include: 1. Resident #135's record was reviewed on 4/26/11 at 2:30 p.m. Resident #135's diagnoses included, but were not limited to, hypertension, stroke, and osteoporosis. A care plan, dated 6/21/10 updated 4/11/11, indicated "At risk for constipation...Stool softener per MD order. Monitor frequency of stool. Laxative		physician notification on 4/26/11 with no other deficiencies noted at that time. 1.3 Director of Staff Development / designee will re-inservice licensed staff regarding physician notification by 5/30/11. Unit Nurse Managers / designees will review five (5) 24-hours reports per unit weekly to ensure physician notification completed for six (6) months beginning the week of 5/23/11. 1.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 6/1/11.	

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	PRN (as needed) per MD order. Increase fluids to resident's tolerance..." On 4/25/11 at 2:00 p.m., CNA #3 reported to LPN #6 that resident #135's stool was "real real hard." The resident's bowel movement monitoring form, dated 3/26/11 through 4/26/11, indicated the resident had hard stools on 3/29/11, 4/1/11, 4/2/11, 4/6/11, 4/10/11, 4/16/11, and 4/25/11. The resident's nurses' notes, dated 4/25/11, lacked documentation to indicate the resident had hard stools,			

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	or of the physician being notified of the resident's hard stools. During an interview on 4/26/11 at 2:37 p.m., the 3A and 3C Halls Unit Manager, indicated the resident had been having hard stools and she needed to see about getting the resident a stool softener. She indicated the nurse should have done something yesterday when the CNA reported the resident was having hard stools. She indicated she was calling the resident's physician. During an interview on 4/26/11 at 3:20 p.m., LPN			

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	#9 indicated she had gotten an order for lactulose (a medication for constipation) for the resident. 3.1-5(a)(2) 3.1-5(a)(3)			
F0253 SS=E	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to maintain a sanitary and comfortable interior, related to an accumulation of a black substance on the rubber caulking of the floor in 1 of 6 shower rooms on 1 of 3 floors. This had the potential to affect 19 residents who reside on 2C. The facility also failed to ensure vent covers inside the residents' rooms were clean and maintained, related to 10 of 16 rooms observed on the 3D unit with rust stains on the vent. (Rooms 383, 384, 390, 391, 392, 393, 394, 395, 396, and 399) Findings include:	F0253	1.1 The black substance on the rubber surrounding the tile flooring in the 2C shower room was removed on 4/26/11. 1.2 All shower rooms were checked for any black substance on the rubber areas surrounding the tile flooring by 4/27/11 with any deficiencies noted corrected at that time. 1.3 The Director of Staff Development / designee will re-inservice staff regarding maintaining a sanitary and comfortable interior related to rubber areas surrounding the tile flooring of shower rooms by 5/30/11. The Director of Housekeeping / designee will	06/01/2011

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	During the environmental tour of the facility on 04/26/11 at 10:55 a.m. through 12:30 p.m., with the Director of Maintenance, the Director of Housekeeping, and the Administrator, the following was observed: 1) There was an accumulation of a black substance located on the rubber that goes around the tile floor in the shower room on 2C. The black substance came off of the rubber upon wiping it with a paper towel. Review of the facility roster, provided by the facility on 4/25/11, indicated there were 19 residents who reside on 2C. During an interview at the time of the observation, the Director of Housekeeping indicated the rubber was old. She indicated the night technician scrubbed the shower room last week. She indicated the shower room was used by all the residents on the 2C unit. 2) During the observation of the 3D hall, there were rust spots all over the vent covers located inside the door of rooms 383, 384, 390, 391, 392, 393, 394, 395, 396, and 399. During an interview at the time of the		audit shower rooms three (3) times per week beginning week of 5/23/11 for six (6) months for cleanliness of rubber areas surrounding the tile flooring. 1.4 The Director of Housekeeping will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 6/1/11. 2.1 Rust spots on vent covers in resident rooms 383, 384, 390, 391, 392, 393, 394, 395, 396 and 399 were sandblasted and repainted on 4/27/11. 2.2 Vent covers in all other resident rooms were checked for rust spots by 4/30/11 with any deficiencies noted corrected at that time. 2.3 The Director of Staff Development / designee will re-inservice staff regarding maintaining a sanitary and comfortable interior related to room vent covers by 5/30/11. The Director of Maintenance / designee will audit five (5) resident room vent covers per unit weekly beginning week of 5/23/11 for six (6) months for presence of rust spots. 2.4 The Director of Maintenance	

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	observation, the Administrator acknowledged the rust on the vent covers. 3.1-19(f)		will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 2.5 Systemic changes will be completed by 6/1/11.	
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure physician's orders and resident's plans of care were followed related to medications for 5 of 26 residents reviewed for following physician's orders and plans of care, in a total sample of 26. (Residents #26, #120, #135, #162 and #163)	F0282	1.1 Regarding resident #135, Unit Nurse Manager / designee immediately assessed resident on 4/26/11 with no adverse reactions noted. Unit Nurse Manager notified physician and family of the occurrence on 4/26/11. 1.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving eye drops on 4/26/11 to ensure physician orders followed with no other deficiencies noted. 1.3 Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding following physician orders related to eye drop medication administration by 5/30/11. Unit Nurse Managers / designees will review five (5) resident MARs with eye drops weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months.	06/01/2011

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	Findings include: 1. Resident #135's record was reviewed on 4/26/11 at 2:30 p.m. Resident #135's diagnoses included, but were not limited to, hypertension, stroke, and osteoporosis. A physician's order, dated 4/9/11, indicated "obtain culture...Garamycin (antibiotic eye medication) opth (eye) gtts (drops) ii (two) gtts each eye bid (twice a day) x (times) 7 days." A laboratory test, dated 4/13/11, indicated the eye culture had very few MRSA		1.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 6/1/11. 2.1 Regarding resident #120, Unit Nurse Manager / designee immediately assessed resident on 4/27/11 with no adverse reactions noted. Unit Nurse Manager notified physician and family of the occurrence on 4/27/11. 2.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving blood pressure medication on 4/27/11 to ensure physician orders followed with no other deficiencies noted. 2.3 Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding following physician orders related to blood pressure medication administration by 5/30/11. Unit Nurse Managers / designees will review five (5) resident MARs with blood pressure medication weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 2.4 The DON will report audit	

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	(methicillin resistant) staphyloccus aureus. A care plan, dated 4/11/11, indicated "(Resident #135's name) has s/s (signs and symptoms) of possible eye infection...Meds (medications) as ordered...." A MAR (Medication Administration Record), dated 4/11, indicated the resident received the Garamycin eye drops once on 4/10, twice a day on 4/11, 4/12, 4/13, 4/14, 4/15, and 4/16/11. The resident should have received another dose of the Garamycin eye drops on 4/17/11.		findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 2.5 Systemic changes will be completed by 6/1/11. 3.1 Regarding resident #162, Nurse Practitioner was already notified on 4/8/11 of the occurrence on 4/7/11 and 4/8/11 by LPN #2. 3.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving nasal spray on 4/27/11 to ensure physician orders followed with no other deficiencies noted. 3.3 Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding following physician orders related to nasal spray administration by 5/30/11. Unit Nurse Managers / designees will review five (5) resident MARs with nasal spray weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 3.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will	

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	During an interview on 4/26/11 at 2:42 p.m., LPN #7 indicated the resident had not received the eye drops as ordered. During an interview on 4/26/11 at 2:57 p.m., LPN #9 indicated the resident should have received another dose of the eye drops. 2. Resident #120's record was reviewed on 4/27/11 at 9:40 a.m. Resident #120's diagnoses included, but were not limited to, hypertension, stroke, and dementia.		monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 3.5 Systemic changes will be completed by 6/1/11. 4.1-A Regarding resident #163, on 4/28/11 resident was at the hospital. 4.2-A Unit Nurse Managers / designees reviewed current diabetic flow sheets related to blood glucose monitoring and sliding scales on 4/28/11 with no other deficiencies noted. 4.3-A Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding facility medication policy and procedure related to blood glucose monitoring and sliding scales by 5/30/11. DON reviewed current practices with Pharmacy, with Pharmacy to supply blood glucose monitoring records in chronological time order beginning 6/1/11. Unit Nurse Managers / designees will review five (5) resident diabetic flow sheets of those receiving blood glucose monitoring and sliding scale weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 4.4-A The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held	

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	The physician's order recapitulation, dated 4/11, indicated clonidine (blood pressure medication) 0.3 milligram/24 hour patch, apply to skin every week on Sunday. The resident's MAR, dated 4/11, indicated on 4/17/11 the clonidine patch was not applied because it was not available. The MAR indicated the resident had received the clonidine patch on 4/24/11 as ordered. Observation of the box of clonidine, on 4/27/11 at 10:40 a.m., indicated the pharmacy had sent 4 clonidine patches on		5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 4.5-A Systemic changes will be completed by 6/1/11. 4.1-B Regarding resident #163, on 4/28/11 resident was at the hospital. 4.2-B Unit Nurse Managers / designees reviewed physician orders and TARs for accuracy related to Lotrimin Cream on 4/28/11 with no other deficiencies noted. 4.3-B Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding facility treatment application procedure by 5/30/11. Unit Nurse Managers / designees will review five (5) residents with treatment orders weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 4.4-B The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 4.5-B Systemic changes will be completed by 6/1/11. 5.1 Regarding resident #26, Unit	

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	4/17/11. There were 3 patches left in the box. During an interview at the above date and time, LPN #9, the 3A and 3C Halls Unit Manager, indicated the resident had not received the patch on 4/17/11 because there was only one patch missing from the box. 3. Resident #162's record was reviewed on 4/28/11 at 8:58 a.m. Resident #162's diagnoses included, but were not limited		Nurse Manager assessed resident on 4/26/11 with no adverse reactions noted. Unit Nurse Manager notified physician and family of the occurrence on 4/26/11. 5.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving eye drops on 4/26/11 to ensure physician orders followed with no other deficiencies noted. 5.3 Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding following physician orders related to eye drop medication administration by 5/30/11. Unit Nurse Managers / designees will review five (5) resident MARs with eye drops weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 5.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 5.5 Systemic changes will be completed by 6/1/11.	

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	to congestive heart failure and macular degeneration. A physician's order, dated 3/26/11, indicated "Nasonex (nasal congestion) nasal spray, 1 spray each nostril daily." An April 2011, MAR indicated the nose spray was not administered on 4/7 and 4/8/11, as indicated by circled nursing initials. The back of the MAR indicated "4/7/11...9am not available told (nurse's name) ordered. Pharm (pharmacy) sent 3/26...4/8/11 unable to find 9a ordered from pharmacy." A nurses' note, dated 4/8/11, indicated "Nasonex spray ordered from Pharmacy. No adverse reactions observed r/t (related to) not received nasal spray. NP (nurse practitioner) here and notified." During an interview on 4/28/11 at 10:05 a.m.,LPN #10, the 3B Hall Unit Manager indicated she had thought LPN #2 had found the nasal spray and administered it. During an interview on 4/28/11 at 10:15 a.m., LPN #2 indicated she could not find the resident's nasal spray. LPN #2 indicated she did not administer the resident's nasal spray on 4/8/11 as pharmacy would have delivered the nasal spray on a later shift.			

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	155214	A. BUILDING 00 B. WING	05/02/2011

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	4. Resident #163's record was reviewed on 4/28/11 at 10 a.m. Resident #163's diagnoses included, but were not limited to, stroke, insulin dependent diabetes mellitus, and hypertension. A. A Physician's Recapitulation Orders, dated 4/2011, indicated "blood glucose monitoring check and record 4 times daily and give Novolog (insulin) 100 u (units)/ml (milliliter) vial per sliding scale (insulin given based on blood sugar results): sub-q (subcutaneous): 60-150= 0 units 151-200= 4 units 210-250= 8 units 251-300= 12 units 301-350= 16 units 351-400= 20 units > (greater than) 400= 23 units < (less than) 60 or >400 call MD." A MAR dated 4/2011, indicated on 4/7/11 at 12 p.m., the resident's blood sugar was 255 and 8 units of insulin were given instead of the ordered 12 units. On 4/18/11 at 6 a.m., the resident's blood sugar was 278 and 4 units of insulin were given instead of the ordered 12 untis.. A care plan for "Diabetes," dated 2/3/11, indicated "...Interventions...Administer insulin sub q as ordered..."	F0282	1.1 Regarding resident #135, Unit Nurse Manager / designee immediately assessed resident on 4/26/11 with no adverse reactions noted. Unit Nurse Manager notified physician and family of the occurrence on 4/26/11. 1.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving eye drops on 4/26/11 to ensure physician orders followed with no other deficiencies noted. 1.3 Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding following physician orders related to eye drop medication administration by 5/30/11. Unit Nurse Managers / designees will review five (5) resident MARs with eye drops weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 1.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 6/1/11. 2.1 Regarding resident #120, Unit Nurse Manager / designee	06/01/2011

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	During an interview with LPN #10, the 3 B Hall Unit Manager, on 4/28/11 at 11:15 a.m., she indicated the insulin was not given as ordered on 4/7 and 4/18. She indicated 12 units should have been given. B. A Physician's Order, dated 4/20/11 at 5 p.m., indicated "Lotrimin Cream apply to glans penis BID (twice a day) x (times) 1 wk (week)..." A Physician's Order, dated 4/22/11 noted at 2 p.m., indicated "D/C (discontinue) Lotrimin..." A TAR (Treatment Administration Record), dated 4/2011, indicated "Lotrimin Cream apply to glans penis BID x 1 wk." There was a lack of documentation of the Lotrimin ever being applied before it was discontinued on 4/22 at 2 p.m. During an interview, LPN #10, with the 3B Hall Unit Manager, on 4/28/11 at 10:50 a.m., she indicated the Lotrimin was not given as ordered until it was discontinued. 5. Resident #26's record was reviewed on 4/26/11 at 11:17 a.m. Resident #26's diagnoses included, but were not limited to, cerebral palsy, seizures, and arthritis.		immediately assessed resident on 4/27/11 with no adverse reactions noted. Unit Nurse Manager notified physician and family of the occurrence on 4/27/11. 2.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving blood pressure medication on 4/27/11 to ensure physician orders followed with no other deficiencies noted. 2.3 Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding following physician orders related to blood pressure medication administration by 5/30/11. Unit Nurse Managers / designees will review five (5) resident MARs with blood pressure medication weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 2.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 2.5 Systemic changes will be completed by 6/1/11. 3.1 Regarding resident #162, Nurse Practitioner was already notified on 4/8/11 of the	

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	A Physician's Order, dated 4/14/11 at 1:20 p.m., indicated "Erythromycin (antibiotic) 0.5% oint (ointment)...QID (four times a day) to Left Lower eye lid x 5 days..." A MAR, dated 4/2011, indicated "Erythromycin (antibiotic) 0.5% oint (ointment)...QID (four times a day) to Left Lower eye lid x 5 days..." It was initialed as given on the following dates and times: 9 a.m. on 4/15, 4/16, 4/17, 4/18, 4/19 and 4/20 (6 days) 1 p.m. on 4/15, 4/16, 4/17, 4/18, 4/19 and 4/20 (6 days) 5 p.m. on 4/15, 4/16, 4/17, 4/18, and 4/19 (5 days) 9 p.m. on 4/15, 4/16, 4/17, 4/18, and 4/19 (5 days) During an interview, LPN #13, with Second Floor Unit Manager on 4/26/11 at 2:56 p.m., she indicated the order was not followed for the Erythromycin, an extra dose was given on 4/20 at 9 a.m. and 1 p.m. 3.1-35(g)(2)		occurrence on 4/7/11 and 4/8/11 by LPN #2. 3.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving nasal spray on 4/27/11 to ensure physician orders followed with no other deficiencies noted. 3.3 Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding following physician orders related to nasal spray administration by 5/30/11. Unit Nurse Managers / designees will review five (5) resident MARs with nasal spray weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 3.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 3.5 Systemic changes will be completed by 6/1/11. 4.1-A Regarding resident #163, on 4/28/11 resident was at the hospital. 4.2-A Unit Nurse Managers / designees reviewed current diabetic flow sheets related to blood glucose monitoring and sliding scales on 4/28/11 with no	

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			other deficiencies noted. 4.3-A Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding facility medication policy and procedure related to blood glucose monitoring and sliding scales by 5/30/11. DON reviewed current practices with Pharmacy, with Pharmacy to supply blood glucose monitoring records in chronological time order beginning 6/1/11. Unit Nurse Managers / designees will review five (5) resident diabetic flow sheets of those receiving blood glucose monitoring and sliding scale weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 4.4-A The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 4.5-A Systemic changes will be completed by 6/1/11. 4.1-B Regarding resident #163, on 4/28/11 resident was at the hospital. 4.2-B Unit Nurse Managers / designees reviewed physician orders and TARs for accuracy related to Lotrimin Cream on	

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			4/28/11 with no other deficiencies noted. 4.3-B Director of Staff Development / designee will re-inservice licensed staff and QMAs regarding facility treatment application procedure by 5/30/11. Unit Nurse Managers / designees will review five (5) residents with treatment orders weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 4.4-B The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 4.5-B Systemic changes will be completed by 6/1/11. 5.1 Regarding resident #26, Unit Nurse Manager assessed resident on 4/26/11 with no adverse reactions noted. Unit Nurse Manager notified physician and family of the occurrence on 4/26/11. 5.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving eye drops on 4/26/11 to ensure physician orders followed with no other deficiencies noted. 5.3 Director of Staff Development / designee will	

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			re-inservice licensed staff and QMAs regarding following physician orders related to eye drop medication administration by 5/30/11. Unit Nurse Managers / designees will review five (5) resident MARs with eye drops weekly per unit to ensure physician order followed beginning week of 5/23/11 for six (6) months. 5.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 5.5 Systemic changes will be completed by 6/1/11.	
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to provide the necessary care and services related to notifying the resident's physician and obtaining an order to treat the resident's	F0309	1.1 Regarding resident #135, Unit Nurse Manager / designee immediately assessed resident on 4/26/11 with no adverse reactions noted. Unit Nurse Manager notified physician and family of the occurrence on 4/26/11. 1.2 Unit Nurse Managers / designees reviewed current 24-hour reports related to physician notification on 4/26/11 with no other deficiencies noted at that time.	06/01/2011

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	constipation for 1 of 26 residents reviewed for the necessary care and services in a total sample of 26. (Resident #135) Findings include: 1. Resident #135's record was reviewed on 4/26/11 at 2:30 p.m. Resident #135's diagnoses included, but were not limited to, hypertension, stroke, and osteoporosis. A care plan, dated 6/21/10 updated 4/11/11, indicated "At risk for constipation...Stool softener per MD order. Monitor frequency of stool. Laxative		1.3 Director of Staff Development / designee will re-inservice licensed staff regarding physician notification by 5/30/11. Unit Nurse Managers / designees will review five (5) 24-hours reports per unit weekly to ensure physician notification completed for six (6) months beginning the week of 5/23/11. 1.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 6/1/11.	

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	PRN (as needed) per MD order. Increase fluids to resident's tolerance..." On 4/25/11 at 2:00 p.m., CNA #3 reported to LPN #6 that resident #135's stool was "real real hard." The resident's bowel movement monitoring form, dated 3/26/11 through 4/26/11, indicated the resident had hard stools on 3/29/11, 4/1/11, 4/2/11, 4/6/11, 4/10/11, 4/16/11, and 4/25/11. The resident's nurses' notes, dated 4/25/11, lacked documentation to indicate the resident had hard stools.			

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	During an interview on 4/26/11 at 2:37 p.m., LPN #9,the 3A and 3C Halls Unit Manager, indicated the resident had been having hard stools and she needed to see about getting the resident a stool softener. She indicated the nurse should have done something yesterday when the CNA reported the resident was having hard stools. During an interview on 4/26/11 at 3:20 p.m., LPN #9,the 3A and 3C Halls Unit Manager, indicated she had gotten an order for lactulose (a medication for			

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	constipation) for the resident. 3.1-37(a)			
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interview, the facility failed to ensure catheter tubing was positioned correctly to reduce the risk for infection for 2 of 3 residents with indwelling catheters in a sample of 26 residents reviewed for indwelling catheters. (Resident #180 and #183) Findings include: 1. During the initial tour on 4/25/11 at 11:40 a.m., with LPN #11, the 3D Hall Unit Manager, Resident #180 was observed in her room sitting up in a	F0315	1.1 Regarding resident #180, on 4/25/11 while resident was in the recliner, the CNA immediately properly positioned the Foley catheter tubing. On 4/27/11, Unit Nurse Manager assisted resident #180 with adjusting her Foley tubing using standard precautions and enabling resident to continue ambulating while maintaining infection control protocols. PT#4 and PTA#5 were directed to wash their hands after touching / readjusting the catheter tubing. 1.2 Unit Nurse Managers / designees completed rounds on 4/27/11 for all residents currently with a Foley catheter to ensure tubing was positioned correctly	06/01/2011

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	recliner. The resident's catheter tubing was laying on the floor. The 3D Unit Manager indicated the catheter tubing should not be on the floor. Resident #180 was observed on 4/27/11 at 11:25 a.m., ambulating in the hallway with Physical Therapist (PT) #4 and Physical Therapy Assistant (PTA) #5. PT #4 was walking along side the resident and pulling her wheelchair behind them. The resident's catheter bag was connected to the back of the wheelchair and Resident #180 indicated the catheter was being pulled. PTA #5 and PT #4 adjusted the catheter bag and tubing by bringing the catheter bag and tubing forward under the wheelchair and hooking the catheter bag onto the resident's walker. The catheter tubing was laying on the floor and as the resident was ambulating the tubing was being dragged and kicked by the resident's feet. Resident #180's record was reviewed on 4/27/11 at 1:50 p.m. Resident #180's diagnoses included, but were not limited to, diabetes mellitus, personal history of urinary tract infection (UTI), and debility. An Admission MDS (Minimum Data Set) assessment, dated 3/23/11, indicated the resident scored a 15 for cognitive status which indicates the resident is cognitively		with no other deficiencies noted. 1.3 Director of Staff Development / designee will re-inservice nursing and therapy staff regarding proper handling and placement of Foley catheter tubing, and hand-washing by 5/30/11. Unit Nurse Managers / designees will complete audit of five (5) residents who require a Foley catheter weekly per unit for six (6) months to ensure proper placement and handling of Foley catheter tubing on all shifts beginning the week of 5/23/11. Director of Therapy / designee will audit residents who require a Foley catheter and therapy services five (5) times per week for six (6) months beginning the week of 5/23/11 to ensure proper placement and handling of Foley catheter tubing. 1.4 The DON and the Therapy Director will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 6/1/11. 2.1 Regarding resident #183, the Foley catheter was removed when the 24-hour urine was obtained on 4/26/11. 2.2 Unit Nurse Managers /	

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	intact. The CAA (Care Area Assessment), dated 3/28/11, indicated Resident #180 was admitted to the facility with a diagnosis of a recent UTI. A care plan, dated 3/17/11, indicated the resident was at risk for urinary tract infection. A nurses' note, dated 4/27/11 at 10:31 a.m., indicated "9:30 am, Resident observed on floor sitting on buttocks leaning against recliner with sensor pad in recliner sounding...Resident more confused than usual." A nurses' note, dated 4/27/11 at 11:30 a.m., indicated the nurse had called the resident's physician concerning the resident's fall and increased confusion. The nurses' note indicated the physician had ordered an urinalysis and urine culture and sensitivity to be done on 4/28/11. During an interview on 4/27/11 at 11:35 a.m.,LPN #10 indicated the catheter tubing should not be on the floor. During an interview on 4/27/11 at 2:10 p.m., LPN #10 indicated the resident had fallen this morning and had an increase in		designees completed rounds on 4/27/11 for all residents currently with a Foley catheter to ensure tubing was positioned correctly with no other deficiencies noted. 2.3 Director of Staff Development / designee will re-inservice nursing staff regarding proper handling and placement of Foley catheter tubing by 5/30/11. Unit Nurse Managers / designees will complete audit of five (5) residents who require a Foley catheter weekly per unit for six (6) months to ensure proper placement and handling of Foley catheter tubing on all shifts beginning the week of 5/23/11. 2.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 2.5 Systemic changes will be completed by 6/1/11.	

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	confusion. She indicated they were going do an urinalysis on the resident today. 2. Resident #183 was observed on 4/25/11 at 1:39 p.m., in her room sitting up in wheelchair. The resident's catheter tubing was observed laying on the floor. Resident #183's record was reviewed on 4/25/11 at 1:45 p.m. Resident #183's diagnoses included, but were not limited to, congestive heart failure and kidney failure. A physician's order, dated 4/25/11 indicated a foley catheter to obtain a 24 hour urine culture. 3.1-41(a)(2)			
F0360 SS=D	The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. Based on observation, record review, and interview, the facility failed to provide residents' diets, which met the special dietary needs of each resident, for 2 of 10	F0360	1.1 Regarding resident #78, yogurt was provided to resident immediately on 4/26/11. 1.2 Dietary Service Manager / designee monitored tray lines for	06/01/2011

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	residents who received supplements in a total sample of 26 residents. (Residents #78 and #135) Findings include: 1. Resident #78's record was reviewed on 4/27/11 at 1:47 p.m. Resident #78's diagnoses included, but were not limited to, Alzheimer's Disease, anxiety, and osteoporosis. A Physician's Order, dated 3/23/11, indicated "Add yogurt to lunch and supper to address low protein stores" Resident #78 was observed on 4/26/11 at 5:12 p.m. in the 2C Alzheimer's Unit dining room. Resident #78 received a roast beef sandwich, french fries, broccoli, and grapes for the supper meal. The resident did not receive yogurt. During an interview with RN #8 on 4/26/11 at 5:15 p.m., she indicated the resident did not get a yogurt with supper. She indicated she would call the kitchen to send one up. 2. Resident #135's record was reviewed on 4/26/11 at 2:30 p.m. Resident #135's diagnoses included, but were not limited to, hypertension, stroke, and osteoporosis.		the next nine (9) meals (4/27/11 – 4/29/11) for supplements given as ordered with no other deficiencies noted. Registered Dietitian and Dietary Service Manager audited all current resident physician ordered diets and nutritional interventions against tray tickets with no deficiencies noted. 1.3 Dietary Service Manager / designee will re-inservice dietary staff by 5/30/11 regarding providing diets and nutritional supplements per physician orders and tray accuracy. Dietary Management designee will audit twenty (20) trays for accuracy three (3) times per week for six (6) months beginning the week of 5/23/11. Registered Dietitian / designee will audit fifteen (15) diet order changes weekly on all units against tray tickets to ensure accurate data entry for six (6) months beginning the week of 5/23/11. 1.4 Dietary Service Manager and Registered Dietitian will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 6/1/11. 2.1 Regarding resident #135, resident was provided magic cup	

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	A physician's order, dated 4/12/11, indicated "...magic cup (a supplement) @ (at) all meals." Resident #135 was observed on 4/26/11 at 12:28 p.m., during the noon meal. The resident had received her meal but had not received a magic cup with her meal. During an interview on 4/26/11 at 2:42 p.m., LPN #7 indicated the resident did not receive a magic cup with her lunch. She indicated she needed to get a hold of the dietician and let her know. 3.1-20(a)		the evening of 4/26/11. 2.2 See 1.2 above. 2.3 See 1.3 above. 2.4 See 1.4 above. 2.5 See 1.5 above.	

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F0363 SS=D	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review and interview, the facility failed to follow menus related to desserts for 2 of 2 meals observed for 1 of 23 residents observed during the meals in a sample of 26 residents. (Resident #183) Findings include:	F0363	1.1 Regarding resident #183, Registered Dietitian provided resident with the menued dessert immediately with lunch meal on 4/26/11. Registered Dietitian provided resident with the menued dessert prior to end of evening meal on 4/26/11. 1.2 Dietary Service Manager / designee monitored tray lines for the next nine (9) meals (4/27/11 – 4/29/11) for supplements given as ordered with no other deficiencies noted. Registered Dietitian and Dietary Service Manager audited all current resident physician ordered diets and nutritional interventions against tray tickets with no deficiencies noted. 1.3 Dietary Service Manager / designee will re-inservice dietary	06/01/2011

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	1. Resident #183 was observed in her room sitting up in her bed on 4/26/11 at 12:20 p.m. The resident received her noon meal tray, which consisted of Lemon Pepper Chicken, O' Brian Potatoes, peas, and applesauce. The resident did not receive the Orange Sherbet Gelatin that was on the menu. The resident indicated she would rather have the jello than the applesauce.		staff by 5/30/11 regarding providing diets and nutritional supplements per physician orders and tray accuracy. Dietary Management designee will audit twenty (20) trays for accuracy three (3) times per week for six (6) months beginning the week of 5/23/11. Registered Dietitian / designee will audit fifteen (15) diet order changes weekly on all units against tray tickets to ensure accurate data entry for six (6) months beginning the week of 5/23/11. 1.4 Dietary Service Manager and Registered Dietitian will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 6/1/11.	

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	Resident #183 was observed on 4/26/11 at 5:12 p.m. in her room sitting up in her bed. The resident received her evening meal, which consisted of a Philly Style Steak sandwich, french fries, and broccoli. The resident did not receive the grapes for dessert as the menu indicated. During an interview on 4/26/11 at 5:23 p.m., the RD (Registered Dietician) indicated the first time the resident had a dessert it "just wasn't the right one." The RD indicated the resident's dessert "was missed" during the evening meal. Resident #183's record was reviewed on 4/25/11 at 1:45 p.m. Resident #183's diagnoses included, but were not limited to, congestive heart failure and kidney failure. A physician's order, dated 4/7/11, indicated a regular diet with diet condiments. 3.1-20(i)(1) 3.1-20(i)(4)			

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F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to store, prepare, distribute and serve food under sanitary conditions related to, a black oily substance on a plastic part inside 2 of 3 ice machines located on 2 of 3 floors (first and second floor), this had the potential to affect 107 residents who reside on the first and second floors of the facility and failed to ensure 2 of 2 microwaves used for residents' food were clean related to dried, splattered food inside the microwave in the 2B dining room, which could affect 10 residents who eat in the dining room and the 3A dining room, which could affect 11 residents who eat in the dining room. Findings include: During the environmental tour of the facility on 04/26/11 at 10:55 a.m. through 12:30 p.m., with the Director of Maintenance, the Director of Housekeeping, and the Administrator, the following was observed:	F0371	1.1 The ice machine located on the Nurse's station on the first floor was cleaned on 4/26/11. 1.2 The Director of Maintenance and the Director of Housekeeping / designee inspected all facility ice machines on 4/27/11 for presence of black substance with any deficiencies noted corrected at that time. 1.3 The Director of Maintenance / designee evaluated current cleaning schedule for ice machines as well as current manufacturer guidelines for cleaning of ice machines; based on same, cleaning / maintenance schedule revised and implemented by week of 5/23/11. The Director of Staff Development / designee will re-inservice nursing, dietary, maintenance and housekeeping staff regarding ice machine cleanliness by 5/30/11. Dietary Management / designee will inspect ice machines weekly for six (6) months for cleanliness beginning week of 5/23/11 with additional cleaning to be completed at that time if needed. 1.4 Dietary Management will report audit findings to the	06/01/2011

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	1. The ice machine located at the Nurses' Station on the first floor had a black substance on the white plastic part inside of the ice machine. The ice machine was full of ice. During an interview at the time of the observation, the Director of Maintenance indicated the ice machine had been cleaned last month. He indicated the facility does not use enough ice and it lays on the plastic and the moisture causes the black substance. 2. The ice machine located on the second floor had a black substance on the white plastic part inside of the ice machine. The ice machine was full. During an interview at the time of the observation, the Director of Maintenance indicated he thought it was from the moisture of the ice because the ice is not used enough. He indicated they would put it on a weekly cleaning schedule. The Administrator, at the time of the observation, indicated the ice was used for all the residents who reside on the second floor. 3. The microwave located in the 2B dining room had splattered dried food on the inside.		Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 6/1/11. 2.1 The ice machine located on the second floor was cleaned on 4/27/11. 2.2 See 1.2 above. 2.3 See 1.3 above. 2.4 See 1.4 above. 2.5 See 1.5 above. 3.1 The microwave located in the 2B dining room was cleaned on 4/26/11. 3.2 The Director of Housekeeping inspected all microwaves used for resident's food on 4/27/11 with any deficiencies noted corrected at that time. 3.3 The Director of Staff Development / designee will re-inservice nursing, dietary and housekeeping staff regarding microwave cleanliness by 5/30/11. Dietary Management / designee will inspect microwaves used for resident's food for cleanliness two (2) times per week for six (6) months beginning the week of 5/23/11. 3.4 Dietary Management will report audit findings to the Continuous Quality Improvement	

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	During an interview at the time of the observation, the Director of Housekeeping indicated the nursing staff should clean the microwave. She indicated the microwave was used for the resident's food. She indicated about 10 residents eat in the dining room. 4. The microwave located in the 3A dining room had a large amount of dried food splattered on the inside. During an interview at the time of the observation, the Director of Housekeeping indicated she would let the nursing staff know about the microwave. There were 11 resident's observed eating their evening meal in the 3A dining room on 4/26/11 at 5:07 p.m. 3.1-21(i)(1)		(CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 3.5 Systemic changes will be completed by 6/1/11. 4.1 The microwave located in the 3A dining room was cleaned on 4/26/11. 4.2 See 3.2 above. 4.3 See 3.3 above. 4.4 See 3.4 above. 4.5 See 4.4 above.	

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F0441 SS=F	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed	F0441	1.1 Upon notification on 4/25/11 of the potential contamination of an ice scoop being stored improperly, the Unit Nurse Manager on 3A hall assessed the hydration cart with no deficiencies	06/01/2011

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	to ensure infection control protocols were practiced by licensed and unlicensed staff related to handwashing and positioning of catheter tubing to prevent potential contamination. This deficient practice had the potential to affect 183 of 183 residents who reside in the facility. (1st floor unit manager, Physical Therapist #4, Physical Therapy Assistant #5, CNA #1, and Residents #116 and #180) Findings Include: 1. CNA #1 was observed on 4/25/11 at 2:45 p.m., passing ice water on the 3A		noted. 1.2 On 4/25/11, Unit Nurse Managers / designees assessed all of the hydration carts that contain an ice scoop and ice bin to ensure infection control protocols were followed with no other deficiencies noted. 1.3 The Director of Staff Development / designee will re-inservice nursing staff regarding infection control protocols to prevent contamination related to proper placement of an ice scoop while passing ice water to residents by 5/30/11. Unit Nurse Managers / designees will check each hydration cart on all units five (5) times per week for six (6) months to ensure infection control protocols to prevent contamination related to proper placement of an ice scoop while passing ice water to residents are followed beginning the week of 5/23/11. 1.4 The DON will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 6/1/11. 2.1 On 4/25/11 the Unit Nurse Manager informed the CNA of the	

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	hall. CNA #1 was observed to place the ice scoop on a paper towel between passing ice water to resident's rooms. 2. There was an ice scoop lying uncovered on top of the ice container on 4/25/11 at 10:27 a.m. on the 3B hall. During an interview at the time of the observation, the 3D Hall Unit Manager, indicated the ice scoop should have been placed in a plastic bag. 3. During a dressing change on 4/26/11 at 10:14 a.m., LPN #12, was observed to remove Resident #116's dressing from her leg		uncovered ice scoop, who immediately removed the ice scoop and ice bin from the hydration cart, and sent to Dietary Department to be cleaned. 2.2 See 1.2 above. 2.3 See 1.3 above. 2.4 See 1.4 above. 2.5 See 1.5 above. 3.1 Regarding resident #116, no adverse reactions were noted related to LPN #12's technique while changing leg dressing on 4/26/11. 3.2 On 4/26/11, Unit Nurse Managers / designees rounded all units to remind nursing associates of following infection control protocols related to hand-washing with no other deficiencies witnessed at that time. 3.3 The Director of Staff Development / designee will re-inservice licensed staff regarding infection control protocols while performing a dressing change by 5/30/11. The Director of Staff Development / designee will conduct two (2) random supervised dressing changes weekly for six (6) months on all shifts with different licensed staff beginning the week of 5/23/11. See 1.4 above. See 1.5 above. 4.1 On 4/27/11, Unit Nurse Manager assisted resident #180 with adjusting her Foley tubing	

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	wound. LPN #12 then cleansed the wounds and then removed her gloves and left the room to get the ointment for the wounds. LPN #12 then returned to the room and indicated she had the ointment in her pocket. She indicated she had washed her hands after she had left the resident's room. She then applied gloves and applied the ointments to the wounds on the resident's leg. She applied the dressings to the resident's legs and applied lotion to the resident's feet. She removed her gloves and gathered the supplies and left the resident's room, without washing her hands.		using standard precautions and enabling resident to continue ambulating while maintaining infection control protocols. PT#4 and PTA#5 were directed to wash their hands after touching / readjusting the catheter tubing. 4.2 Unit Nurse Managers / designees completed rounds on 4/27/11 for all residents currently with a Foley catheter to ensure tubing was positioned correctly with no other deficiencies noted. 4.3 Director of Staff Development / designee will re-inservice nursing regarding proper handling and placement of Foley catheter tubing by 5/30/11. Unit Nurse Managers / designees will complete five (5) audits per unit of residents who require a Foley catheter weekly for six (6) months to ensure proper placement and handling of Foley catheter tubing on all shifts beginning the week of 5/23/11. 4.4 The DON / designee will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months with the next meeting to be held 5/31/11. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 4.5 Systemic changes will be completed by 6/1/11.	

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During an interview on 4/26/11 at 10:22 a.m., LPN #12 indicated she should have washed her hands.

A policy, titled "Dressing Changes-Wounds", dated 8/09, provided by the Director of Nurses as current, indicated ",,,Remove old dressings, remove gloves...wash hands...apply medications/dressings....remove gloves...wash hands..."

4. Resident #180 was observed on 4/27/11 at 11:25 a.m., ambulating in the hallway with Physical Therapist (PT) #4 and Physical Therapy Assistant (PTA) #5. PT #4 was walking along side the resident and pulling her wheelchair behind them. The resident's catheter bag was connected to the back of the wheelchair and Resident

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	#180 indicated the catheter was being pulled. PTA #5 and PT #4 adjusted the catheter bag and tubing by bringing the catheter bag and tubing forward under the wheelchair and hooking the catheter bag onto the resident's walker. PTA #5 and PT #4 did not put on gloves or wash their hands before or after adjusting the catheter tubing. The catheter tubing was laying on the floor and as the resident was ambulating the tubing was being dragged and kicked by the resident's feet. At 11:28 p.m. another resident stood up from her wheelchair and PTA #5 and PT #4 went to assist the resident touching the resident as they assisted her. PTA #5 and PT #4 then returned back to Resident #180 touching the resident, the resident's wheelchair, and walker. During an interview on 4/27/11 at 11:35 a.m., LPN #10 indicated the therapy staff should have worn gloves and washed their hands after adjusting the catheter tubing. She indicated the therapy staff should wash their hands between residents. A facility policy, titled "Hand-washing", dated 5/10, received from the DoN (Director of Nurses) as current, indicated "...Hand-washing should be performed anytime the hands are accidentally soiled, after glove removal, and between resident contacts."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HOME	203 FRANCISCAN DRIVE CROWN POINT, IN46307

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	A facility policy, titled "Water Collecting and Replenishing Drinking Water", dated 8/09, received from the DoN as current, indicated "...Covered ice containers...along with a scoop in a clean plastic container...." 3.2-18(j) 3.1-18(l)			